City of San Jose

Former San Jose Medical Center Site
Land Use – Health Care Study

Stakeholder Advisory Committee Meeting
200 East Santa Clara Street, Combined Rooms W118 and, W119
(San Jose City Hall, Council Wing)
Thursday, August 24, 2006
6:00 – 8:00 p.m.

MEETING NOTES

Committee Members Present: George Chavez, Roz Dean, William Gilbert (Represented by Gary Schoennauer), Nancy Hickey, Dennis Hickey, Les Levitt, Jim Murphy, Julia Ostrowski, Patti Phillips, Joe Pambianco, Andrew Reid, Robin Roche, Paula Velsey, Ernie Wallerstein

Staff Present: Kip Harkness, Jeannie Hamilton, Cesario Rodriguez, Rodrigo Ordoña

Consultants: Henry Zaretsky and Karen F. Taranto

1. **Welcome**

2. **Introduction - Health Care Consultants** – Henry Zaretsky and Karen F. Taranto. Staff noted that the land use consultant will be Terrence Bottomley and will be present at the next meeting.

3. **Committee Discussion on Meetings**

    a. Request was made that any changes in meeting dates involve the committee for discussion and not be solely staff decision. Staff agreed to include the committee on any future changes.
    b. It was requested that email lists be confirmed. Staff to send out a post meeting email with summary and any materials distributed. The persons attending the meetings and have provided email addresses will also be notified.
    c. Next meeting will be September 20, 2006.
    d. San Jose State needs to be represented. Needs approval by City Council. There is a state rep on the UNC board and she is in the audience, Angela Harper, assist. Dir. of Sorority and Fraternity life.
    e. Recommended that ground rules for committee member attendance be established which will be an item for the next committee meeting.
    f. A future agenda item should be the choosing of staff looking at the financial/economic side.

4. **Interactive Overview of Health Care Issues –**
    a. Mr. Zaretsky presented an overview of the SJMC Closure Impact Study completed previously, which was concerned with current and future healthcare needs of the downtown population.
    b. Question & Answer; Comments & Discussion

i. The growth projections (2.5%) for downtown seem low? Possibly; the rate was a concern of the Technical Advisory Committee for the study. Rate was obtained from the Association of Bay Area Governments (ABAG) Projections for 2003. There may be updated numbers and if available will consider those.
ii. In the comments as to the effects of closure, the effects on trauma center were not mentioned (?). It may no longer be an issue as Regional Medical Center has established a center. However, at the time of the first study it was a concern particularly by the Police Department. Yes, police had mentioned that there was some violence, and one or two police mentioned that if travel to a trauma center was increased a few minutes the outcome would not have been as good. However, this is an unusual community in there are not too many communities that have three trauma centers in such close proximity: Regional is three miles away, Valley Medical Center is five miles away and then there is Stanford, may not be relevant in this case. The major concern is the emergency room, not every community can expect a trauma center.
iii. Would the proximity of a trauma center be more important given the density of downtown? Isn't the trauma center time dependent? Yes, it is time dependent, but the nearest one is only two and a half miles away, very close to freeways. More trauma cases would probably come from traffic accidents than gunshots. A trauma center is important, but it is not a reason to keep a hospital open. The reason given to close the hospital was because it required major capital improvements due to seismic safety codes that were enacted in 1994, and it did not have a good payer mix in terms of a lot of MediCal, which doesn't pay very well, and the rest Medicare. The best with Medicare is that the service provider breaks even, not very many hospitals are profiting on it. With Medical, most hospitals lose money. Hopefully, through this project the architectural analysis HCA had can be obtained, as one of the tasks in the scope of services is to look at what those buildings can be used for.
iv. What are the basic the differences between an emergency center and a trauma center? A trauma center has to have a lot of medical capability. Different specialists have to be e not on call given the traumatic condition of patients. This staff does the real heroic stuff. A large number of the patients going to trauma centers really don't have to go there. Basically, it's a super emergency room. But the hospital has to have a lot of capabilities that most hospitals don't have.
v. Where does Good Samaritan Hospital fit into this? It doesn't that much as it does not draw many patients from the downtown area, although, some of the services from San Jose Medical Center were moved to Good Samaritan - rehab, OB, maybe psychiatric. HCA was a three hospital system with Good Samaritan, Regional and San Jose Medical, now it's a two hospital system.
vi. Comments: The initial study addressed two issues, which are access to emergency care and the more general question of access to primary care, beds, etc. Suggest that the question of how does the access to emergency care really work given the expansion at Regional not only for a trauma center, but expansion of the emergency room. That issue needs to be assessed and how it compares around the county. It is inappropriate to look at downtown as some kind of unique piece of geography because it is not unique. The study has to look at that question whether it's statistics, impacts, travel times. The travel times from downtown to nearby hospitals for emergency treatment is not unique in the county. That needs to be assessed to understand what the committee is dealing with. Secondly, look at how downtown residents get access to routine primary care physicians, another big issue as physicians have moved out of the area closer to other hospital campuses. When looking at beds, more than Regional Medical Center, Valley Medical and O'Connor have to be looked at. Clearly, Good

Sam and Kaiser are in the market area when it comes to beds because beds are not the kind of facilities, as indicated earlier, that are a problem. The original study mentioned that there could be a shortage of beds come 2015 or 2020 depending on how you count the beds. It seems that if the broader market question is looked at, do you build a smaller hospital downtown to create the beds, or do these other large campuses like Good Samaritan, Valley Medical Center, Kaiser, Regional Medical Center, which is it more feasible and viable. Beds are usually added on basis of market demand. Finally, it seems that evaluation of a continuing care retirement community just seems off track relative to the question of how do we provide health care to downtown residents. Retirement communities are a very unique form of housing. That particular work item should be dropped from the scope just to expedite things and to keep this group focused on the principal mission which is to look at the issue of health care and whether or not the San Jose Medical site has any future in that regard. Mr. Zaresky Comments: He agreed with most of the comments. In doing the last study, it was not suggested that the hospital had to necessarily be located in downtown. O'Connor, Valley and Regional were considered to also be serving the downtown area. Kaiser was not a focus of the study as it is closed to the non-Kaiser patients. Focus was on hospitals serving the area and access to the services given the issue of transportation access. In terms of the retirement community issue, the real need is medical care and a retirement facility is not necessarily medical care. A nursing home is a possible consideration. One of the previous study's recommendations was to convene a planning effort by the city to look at building a downtown hospital on this site relative to the cost effectiveness of adding capacity at other existing hospitals. That is implicit in this whole thing.

vii. Comment: Having something some pseudo medical use at the site at all costs should not be a primary objective unless it meets a known and defined gap – i.e., emergency services and the possibility of having local beds.

viii. Should the look at the continuing care community be part of the scope of services so that there would be some evaluation of that option that is brought back to this group? There was a finding in the first study that cited there was some portion of downtown that was viewed as aged with needs. Aging comes in different forms, acute care being one. Building an acute care hospital is going to be difficult, so what sort what sort of ambulatory services that focus on geriatric needs may be appropriate, so I may put it onto the ambulatory care, primary care piece. Informal neighborhood meeting discussions on this issue aren't focused on the retirement homes, but on the spectrum of care that downtown needs. If a retirement home is needed, because of a rapidly aging population, and an emergency room, the focus was not on retirement or the retiring community as a whole, but on the medical need, not the housing needs. It was commented that it is not a big issue in terms of the medical and health care, but the scope reads – long term care, etc., which is not the charge of this committee.

ix. Comment: The study needs to keep focused on the fact that whatever is decided is for the future and not just the current needs. Whatever is developed will take seven years or so before property is developed which is a long time, by that time it's obsolete. Need to plan for 20 year. Look at the gap in the future and beyond.

x. Comment: Look at a more refined version at what the gap is in terms of the health services that the population will need. One of those groups is going to be the aging population, which is growing very rapidly downtown and also requiring more health services.

xi. Comment: Ambulatory care is evolving. Bed capacity and bed needs are going to be impacted by changes in technology and how health care is delivered. A greater

number of people may need fewer hospital beds, but emergency services and outpatient services are where the needs are

xii. Were San Jose State University students was a consideration in the initial study? Yes, students generally do not use hospital services – estimated that the demand from that group was one bed. It is known what the average students use of care is, and it is not very, much. However, consider that students use there parent's address and thus may not reflect as students on medical records. The numbers show projection of a greater student enrollment, which was included in ABAG numbers.

xiii. Comment: Consider the use of medical facilities by SJSU, by the staff, which is an older population. Note that new living facilities include provision for staff and families

xiv. Comment: As study proceeds, the foundation may be based on statistics, but take the committee beyond that by providing an understanding of the dynamics of the changing health care industry. What facilities may be needed based on these changes? Provide a picture of the business dynamics of the health care industry. Facilities are being built. Why are they being built where they are being built, and by who, and how do those case studies relate to what's happening in the downtown area.

xv. Comment: I live in Paseo Plaza, I see young people moving in. I would question this aging population thing for downtown.

xvi. Comments by Mr. Zaretsky: SJMC did have skilled nursing home beds. Question is what happened to those patients? While there may not be concern with a retirement community, there still may be need for long term care, a nursing home. To have an emergency room you need a hospital, the best you can get without a hospital is an urgent care center. If we can get by with an urgent care center, open 24-7, that can treat emergencies and send to a hospital, that would be the alternative. The questions about the aging population, increase students and faculty, is more reason to check back with ABAG or whoever is doing projections to see if that has been incorporated. If it hasn't that is something to take a look at.

c. How to proceed?

i. First priority, see what's happened since the closure, how has the community adjusted, how has the industry adjusted, what has been the impact on the other hospitals/emergency rooms, what's been the impact on physician offices, what's left down here, where have they gone, where are the people now getting care, what's happened to the clinics, how does the community feel. Does the community feel they really have a problem now then before? The deliverable would be some kind of write up including charts, addressing each of those issues

ii. Based on the core piece around emergency services, did the worse thing happen, did emergency services access, slide one way or the other appreciably, can you get at that. We can talk to Valley Medical Center, that's picked up a lot of the pieces, O'Connor and Regional and look at the origins of the patients going to those emergency rooms, are there more from Downtown, are there more admissions, or serious emergencies than there was in the past. Wouldn't look at mortality in the area, it would not be statistically significant. Determine how the affected hospitals and physicians have adjusted regarding what new services were introduced because of that, have they expanded capacity; what is happening to the family practice residency, whether the adjustment been smooth, are they seeing the same patients they saw before only in a different location. At the tail end of the previous study, O'Connor was to have opened a clinic close to downtown, just south of 280, what's been going on there, have they been picking up some of the pieces. Also what plans hospitals, clinics and the medical groups have for the future, are they going to add beds, whose going to add beds, what

kind of beds are they going to add. The deliverable there would be a synopsis and that should take us to the next meeting at least or beyond.

iii. Another item after that, is to survey interest in the site on the part of the county, one of the recommendations was that Valley Medical put in a comprehensive clinic at the site, to see if there is still interest, if not why; and to talk to Gardner, the major nonprofit clinic in the area, and talk to skill nursing facilities operators to see if there is interest; a new medical office building would be highly desirable with an ability to move patients around between Regional or the other hospitals. And an assisted facility, though which would not be a priority.

iv. And one of the items is still the feasibility of a hospital in the area. In terms of looking at that, when the report was released it did get a lot of press throughout the state, November 2004. Various hospital operators knew there was possibly an opportunity and I don't know if anybody jumped on it, which is something to talk about. It's like if they build it they will come a movie, that's not quite the situation because of the payer mix and also because of the potential hospital operators, Tenet is no longer in the expansion mode, Sutter has its hands full, they're building a hospital up the peninsula, Catholic Healthcare West which use to own O'Connor, I don't think would won't want to come in and compete with O'Connor. So that leaves you with some physician investors. I don't know how sensitive the community is to a physician owned hospital is unless it is owned by the physicians in the community, not some these southern California Orange County types that come in and build hospitals drain them and leave. But there could be some interest by the local physicians.

v. First two priorities are getting caught up with what's happened in the last year and a half, throughout the medical community and the community in general, and then determine how people, providers and the community are adjusting and what the future plans are…

d. Additional Discussion

i. One of the interest is that now that there is no hospital operating there, is there anything magical about that site versus some other sit in the downtown? We have a land use study going on and we have this hospital study, wonder if there is some kind of overlap at some point that says to determine, if there something special about that location versus others, can we meet that, is there a sense as to where that belongs? What is special about the site is that it is zoned for that. That question will weave together the health care piece with the land use piece. Once the land use consultant is on board to work with Zaretsky, that will be one of the things the committee will work to address, to say if there a gap in some kind of service, is this the right location for it

ii. Comment: Feasibility should also consider size of the site, 13 acres, nobody is building hospitals and sites of this size. The City Council imposed a look a 5 acres to be reserved, which is even smaller. Size needs to be part of that equation, in terms of viability/feasibility, given the opportunities. As a general piece of information, the expansion of Regional Medical Center on 38 acres, is approaching $400 million on a site where they are still able to do provide surface parking, not building parking structures. That is enormous just for the first phase. Re-certifying the old buildings at San Jose Medical would be virtually impossible as a hospital and should be confirmed for this committee. That becomes an academic issue when it comes to feasibility. Mr. Zaretsky Comment: There are two standards, 2008 and 2030. The 2008 standards are that the hospital has to be standing after an earthquake. The 2030 standard is that not only does it have to be standing, but also has to be operational. Legislation is currently under consideration, is to scrap the 2013 standard, move it to 2020, but build under the 2030 standards. Re-building on the site is going to be expensive. No one has jumped to the opportunity, which makes it unlikely. Tenet, for various reasons

was forced to sell several of its hospitals in California, but they were not sold at a very good price. Possibly, all were sold to the physician hospital operators in Southern California who don't have the best reputation in the community for quality care and/or for financial management. Would not like to see that as an alternative.

iii. Comment: Status of legislation will be presented to the committee. There was discussion at this legislative session, which is going to be deferred to the next session, about the state doing some bonding to help hospitals pay for seismic retrofit. Request that it be look at.

iv. Comment: In terms as to how the hospitals have adjusted, would like to see what has been the impact on quality of care in the community, have DHS investigations and sustained complaints risen at Regional Medical Center and other places since the closure. Have the hospitals acquired infections, has there been a rise in those. It's difficult to quantify as was mentioned, mortality rates aren't necessarily a good example, to the extent possible look at how the quality of patient care's been affected. Mr. Zaretsky Comment: It would be difficult, but will see what is feasible.

v. Mr. Zaretsky Comment: I believe you're going to need more beds to serve the downtown area. There has been drop in hospital utilization because of changing technology and style of medical care, but appears has bottomed up. Reason for the drop, a lot of it was managed care, which has prompted more creative ways to treat patients to keep them out of the hospital. But there has been that backlash against managed care in the last few years. The safest assumption should be the hospital utilization is not going to drop substantially from what they are now. Based on that it did show a need for beds around 2015-2020. It does not mean the beds have to be located downtown or in the same facility. They could be located at expansions at area hospitals or a hospital downtown. There is going to be a need for beds somewhere serving the downtown area.

vi. Comment: In the previous study, it did mentioned looking at emergency room use now, which would include waiting times as compared to what they were. Location in the memorandum where City Council established committee, in the charge identifying 5 acre site, if necessary, staff to identify other potential, viable, long term healthcare sites. Any site should meet certain qualifications. The city has land banked in the past. Acquiring the land at this site, is such land banking, for building or for bargaining for a site elsewhere.

vii. Comment: Care mix, access may not be the same for all members of the community. Why are hospitals being built at certain locations – because there is a business plan, that it's a profitable patient population, and the service will make sense, and there's a demand. For some hospitals the mission is a little different, trying to raise revenues, but in the end that sort of continual incremental access for certain services will leave gaps, and ultimately that gap is what we're talking about here, so, the long term solution is not one that's going to be built out of bond money tomorrow because the payer mix won't support it. It's going to take some time. Factor in payer mix and access.

viii. Comment: Consider that there is an existing medical office building across the street, 80,000 square feet, with a foot bridge across between the fourth floor of the hospital…

ix. Comment: One fear expressed by the neighborhood when this issue is discussed – in a countywide emergency, is there something special about the population density downtown and the geographical location, traffic problems, that would make it difficult to travel two and a half miles away to Regional. Mr. Zaretsky Comment: Creeks were an issue. Not every community has a hospital right there. In past work, standards use to be that access be within a half hour, but that varies depending on time

of day. There is not a generally accepted answer. This is the generally accepted answer.

x. Comment: In representing neighborhood interest, more interested in getting the medical care needs met than having a great neighbor; the kernel of this issue is emergency service, secondary, is having a great neighbor. If there are sites elsewhere not adjacent to residential, something that could enhance a neighborhood. This summarizes the use of the site framework - provide medical care and be a good neighborhood.

xi. Comment: Reminder that the Transportation and Land Use Coalition did a study on transportation availability for people without cars, if the hospital is there or if it is not there.

xii. Comment: Concern for low income people in the neighborhood's loss to primary care since hospital closure. This is a major concern in the neighborhood.

xiii. Comment: Primary concern that the opportunity to make it into a needed medical facility remain. Are there are other interests that conflict with making it into a hospital? HCA Comment: No one is interested in making it into a hospital. A lot of interest in housing, affordable housing, huge demand. Generating retail, and other things neighborhood wants. Comment: Gardner was interested.

xiv. What are HCA's plans now with the re-structuring, and it's effect on expansion at Regional? No effect as far as HCA representative knows.

xv. Discussion on Scope of Services for a Healthcare Study Item 3.,"Opportunities Assessment – Continuing Care Retirement Community - Investigate the opportunities of including a continuing care retirement community." Given the discussion above, including comments that such a proposal did not necessarily serve community versus emergency services or other medical use, there was recommendations for removal. A straw poll resulted in holding the item in abeyance. If it becomes an issue to address, it can be included as it was not considered a priority.

xvi. Comment: Question is, if there is a catastrophic event will the freeways and overpasses be standing, will downtown be an island.

5. Proposed Work Plan

No changes to schedule suggested based on the evening's discussion. Next meeting Sept 20. Land Use consultant will attend the next meeting. We will begin to look at finance issues when there are some scenarios to look at such as, understanding size of different facilities and costs. Technical resources will be reported at the next meeting. On the Scope of Services for a Healthcare Study Dr. Zaretsky will focus on #'s 1, 2, 4 and 5. He will not focus on # 3 until it appears necessary. If discussions emerge that the continuing care option, or some variant of it, becomes a scenario we would like to examine we will then spend some time on it.

6. Public Comments

Comments made during committee discussion.